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(Re)Making Choice and Autonomy in Publicly Provided Maternity Healthcare

This article is concerned with healthcare institutions' principles of choice and autonomy in the care practices of maternity healthcare provided by the Nordic welfare state. The issue is explored through analysis of institutional ethnographic material collected at four different maternity healthcare clinics in one large city in Finland. The analysis shows that nurses remake the medical institutions' demands for choice and autonomy in healthcare. In the nurses' experience-based knowledge of pregnancy, choice is not just a static activity but something that is achieved through a process of coming to know one's choices. Choice as a process involves experiencing pregnancy, and the nurses' respect for this process can be understood as enabling motherhood. The nurses encourage the women to be self-reliant and autonomous. This increasing demand for choice and autonomy may also be interpreted as a demand of consumer capitalism. The welfare service response has been to treat women to an extent as neoliberal reflexive individuals, in effect, responsible for their own motherhood. These nursing approaches to providing choice and autonomy for pregnant women both potentially enable and control motherhood.

There has been a recent shift toward more patient choice and autonomy in social and health care, even in the large redistributive welfare states of the Nordic kind. Scholars on healthcare, maternity, and other issues claim that the state no longer guarantees the good life in general, and good motherhood in particular, for its citizens. Instead, it delivers them indirectly, as responsibility is shared by peer citizens, such as family, friends, communities, and private and third sector agencies (Beck-Gernsheim; Sulkunen; Lawler; Homanen, "Enabling and Controlling Parenthood").

It would be an exaggeration to state, however, that becoming a mother in a Nordic welfare state is nowadays mostly a personal and private achievement. The welfare model can still be characterized, as it has been, as a guarantee of social support and as enabling (as well as

controlling) parenthood (Sulkunen; Homanen, “Controlling and Enabling Parenthood”). In this article, I will attend to the everyday work of maternity nurses in negotiating the pressures of providing greater choice and autonomy for mothers-to-be. These pressures have been interpreted in prior studies as a state response to market demands for the welfare state to offer to, and require of, its citizens more choice and autonomy (Sulkunen; Homanen, “Enabling and Controlling Parenthood”).

My article draws on an ethnographic research project about the institutional constitution of maternal-fetal relations in nursing. The project was based on ethnographic fieldwork at four different maternity healthcare clinics for three months between 2006 and 2008. I assembled the material through multiple methods of data production, including video recording (sixty-nine videos), observation, interviews (fourteen), and documentary material, including guides and handouts identified by the nurses as being relevant to their work. My analysis is intertwined with the collection of the material as is common in (institutional) ethnography (Smith). Ethnographic research always produces knowledge collaboratively; it is produced through the researcher’s constant interaction with the field.

In Finland, maternity healthcare services have historically been provided by midwives and public health nurses in maternity healthcare clinics rather than by doctors in hospitals (Benoit et al.). The clinics are often located in clients’ neighbourhoods, and pregnant women meet with their appointed nurse approximately ten to thirteen times during their pregnancies. The care is state funded and involves support in the form of advice and information—for example, guidance on healthy lifestyle and preparing for birth and control over somatic changes experienced by the pregnant woman and the fetus, which include ultrasound screenings. Furthermore, attention is

paid to the psychosocial home environment by encouraging the future parents to reflect on and discuss issues of family life, such as home arrangements and parenting choices.

This kind of care—which includes social support alongside medical screenings and long-lasting, client-professional relationships and care that replaces doctors with nurses—corresponds to the suggestions made by many writers about desirable maternity healthcare that supports pregnant women's agency and reproductive freedom (Oakley, *The Captured Womb* and *Social Support*; Wrede). Technology-driven medical professional practice, conversely, has been perceived as undermining women's experience-based knowledge (Martin; Wajckman).

The care work I have studied does not, then, totally rely on medical institutional demands but reworks them with complementary models of experience-based knowledge and an insistence on trusting professional relationships and treatment decisions established over time. The specific focus of this article is to discuss the possibilities and limitations that the nurses' reworking of demands for choice and autonomy provides for pregnant women's motherhood.

The nursing approaches to choice and autonomy that I have studied can be seen as both enabling and controlling motherhood. In the following, I explain this process by first describing how the nurses balance a commitment to a medical ethical principle of (static) informed choice with a more intuitive perception of choice based on the nurses' experience of working with pregnant women over a long period of time. This understanding of choice recognizes that choice is achieved in a process of coming to know one's own motherhood and maternal choices through experiencing pregnancy. I will also discuss the nurses' respect for this process of coming to know one's own motherhood and their subtle guidance of pregnant women to becoming autonomous and self-reliant as a parent.

Static-Informed Choice and Choice as a Process of Coming to Know Motherhood

The highly valued Western ideal of respect for patient (informed) choice shapes daily care at the maternity healthcare clinics, where staff members are held institutionally accountable to clients for not influencing their decisions. According to my analysis, there are two logics of choice realized in such care practices. They are related but in a frictional way. I will discuss these logics through two example practices: discussing attending fetal screenings and discussing fears of giving birth.

Screenings for fetal abnormalities are discussed as early as the first appointment because the first ultrasound is done between the nurse's and the pregnant woman's first two meetings. During these appointments, the nurses can be reticent about discussing the fetal screenings (Mitchell and Georges). They often refer to the material sent in advance to the future parents, and sometimes simply ask if the pregnant woman has decided whether she will make use of the screening service. If they do give any further elaboration, they usually restrict themselves to "neutral" information about screenings, and are careful about not mixing biological facts with values, virtues, and emotions.

The leaflets sent in advance consist of fairly technical and clinical information in line with local and national nursing standards, norms, and procedures (*Handbook for Maternity Healthcare*; Viisainen). They reveal the probabilities of detecting different structural deformities in screenings (*Foetal Screening I and II*). Furthermore, the leaflets as well as the nurses' choice of approach take patient autonomy as a self-evident good by stressing that the choice to attend the screenings is and should be voluntary and that the (difficult) decision about further care is one that only the parents have a right to make.

This approach to screenings is framed by a medical ethical repertoire allied to biomedical knowledge of the potential occurrence and mechanisms for the genesis of abnormalities. It is unsurprising that health workers restrain themselves to giving neutral biomedical facts about screening for somatic abnormalities when it comes to making decisions about diagnostic tools or treatment. Biomedical scientific knowledge is a powerful cultural tool for such a purpose of expressing neutrality because it holds such a position of authority (of knowing best) in our times (Foucault, *The History of Sexuality*; Haraway).

However, it seems that a nursing approach that relies on emotionally detached facts and does not take a position in relation to making treatment decisions is not the only one possible. Discussing fears of giving birth at the appointments is a good example of an alternative approach. In Finnish healthcare, in cases of severe fear, a referral to a special outpatient clinic is made, and a Caesarean section is only planned if the pregnant woman and the outpatient clinic staff fail to work out a vaginal birth delivery plan that eases the pregnant woman's anxieties. However, a series of discussions at the maternity healthcare clinic precedes the referral as seen in the following sequence:

A pregnant woman and a nurse are talking about a birth class arranged at the local hospital maternity ward. The nurse explains the agenda for the class, which is to go over "the normal course of delivery, pain relief, suction cup use and abnormal births." At this point, the pregnant woman first expresses her fear of medical instruments by saying that she has heard criticism about the class and that she cannot stand doctors' equipment. They make her disgusted, and she does not want to be near such things. She further asks the nurses' opinion about whether she should attend at all. The nurse comments that "of course one does not have to go" and then goes on to explain all the "useful and good information" one gets from the classes. She then suggests that the woman could skip the part during which a video of a real birth and instruments involved is shown. "Good stuff that all women wonder about" she concludes. The pregnant woman remains quiet at first and then repeats her worries about the delivery class and instruments. She intensifies her fear and problem by saying that she even hates going to the dentist.

At this point the nurse asks her how she thinks she will handle the birth itself if she is so worried about attending the instruction class. It turns out that the pregnant woman does not know if she will be able to handle a vaginal birth because of her fears. All the while, it seems that the nurse is implicitly striving for the woman to express doubt about wanting a Caesarean section: she uses leading questions and comments, such as “but you don’t have this feeling that you absolutely want a section, do you?” The pregnant woman says that she is not sure about vaginal birth and that she has actually thought that she will just have to “survive” it. Here, the nurse seems to reassure the obviously worried woman by telling her that she will certainly refer her to the outpatient clinic and that nowadays it is possible to perform a Caesarean without a purely medical reason. She talks about patient autonomy, and how a birth should be “an active event” so that “nobody is forced into a vaginal delivery.” However, the nurse wants the pregnant woman to calmly think through things because “there is still a lot of time before [the estimated birth date]” and because “one might think differently later on [in pregnancy].” It is agreed that they will talk again in a few months about the birth mode.” (Videotape of a woman twenty-two weeks of gestation, first pregnancy)

We discussed this video clip with the nurse after the recording. I pointed out to her that she did not really answer the pregnant woman’s question about her opinion on whether she should attend the class and that she pushed the decision of referring the pregnant woman to the outpatient clinic into the future. This comment was based on my confusion over the nurses’ tendency to push the decision about birth mode into the future and how it showed a reluctance to take the women’s concerns into account. It seemed a reluctance to abide by another principle of Western medical ethics: beneficence. Beneficence ensures that the best interests of the patient are taken into account by medical professionals (Held; McLean).

The nurse explained in a frustrated manner that the pregnant woman asked her questions she could not really answer because the official protocol states that women have to make the choice themselves. In this way she, in fact, addressed the medical-ethical logic of doing care that was brought implicitly into our discussion by me but from another angle: the principle of respect for informed choice and autonomy. She then went on to elaborate that in her professional opinion

based on her experience, women change their minds about the birth mode, sometimes many times, as the pregnancy proceeds. Thus, it made no sense to her to make any definite decisions about the birth mode at this early stage.

It is possible, then, to interpret the nurses' encounters with women as not just disregarding their concerns or needs. This nurse's argument allows an understanding of care within which choice is not a momentary or static activity but is a process of realization or, as I like to call it, a "coming to know" one's choice. Care practices and the nurses' experience-based knowledge are constrained by ethical-medical mantras that are realized in terms of "patient autonomy," birth as an "active event," and "parental choice." This is the voice of the institutional order deriving from policy documents and nursing education. However, the nurses' intention and perspective remake it through realities of care that lead to respect for informed choice as a process rather than a static activity (see also Homanen, "Reflecting on Work Practices").

This is how beneficence, to use the medical ethical term, concerning the choice over birth mode in the working lives and experiences of the nurses is realized and that is how it *works* as an institutional standard in my interpretation. The nurses may move the concern about giving birth into the future because "one might think differently later" in pregnancy. Later, they will act if the women feel it necessary. They do not simply deny the women's concerns but encourage them to experience more pregnancy in order to know their preference for birth mode better.

Looking carefully into these practices, then, it turns out that the medical ethical repertoire of static choice sometimes manifests merely as phrases in a dialogue the nurses are required to utter and in cases of certainty to act upon. In maternity healthcare practices, it is realized to a certain degree that choice is a process (Kingdon; Mol) through which respect for motherhood is enabled rather than controlled.

Subtle Support of Women to “Naturally” Become Autonomous and Self-Sufficient as Mothers

A subtle and delicate approach to managing women’s feelings toward both medical uncertainty in pregnancy and also toward changes to a family lifestyle is characteristic of this care work. According to my observations, the nurses delicately support and negotiate a (perceived to be) natural process that, to a large extent, is expected to unfold by itself, for women at least. This is observable in the following excerpt from my field notes.

A family counselling class at a clinic. A nurse is showing transparencies about parenthood on the overhead projector. There are different transparencies for “fatherhood” and “motherhood.” The fatherhood transparency describes fathers in terms of “safety,” “love for the family,” “friends for mothers” and “carers for babies.” Then she notes that the father’s role is different from the mother’s and that women have a nine-month head start on motherhood: women, according to her, “have pregnancy and baby issues on their minds all the time during pregnancy.”

It is implied in the ethnographic snapshot above that unlike men, women are expected to acquire parental identity naturally by “having baby issues on their minds.” They are also assigned the task of nurturing, which they acquire (mostly) through their “nine-month head start.”

The nurses rarely explain how to perform the desired characteristics and roles assigned to desirable motherhood (or fatherhood)—for example, how performing “love” and “safety” is done in the case of fathers or how the “growing of one’s own maternal instinct,” as often mentioned by the nurses, is done in the case of mothers. On the contrary, they often emphasize the important roles of the parents themselves and their intimates in the work of defining parenting

methods and good parenthood, just as the nurse cited above did later in the same class. “She notes that everybody does [parenthood] in their own way. The nurse expresses her personal preference for an upbringing that relies on ‘traditions’ and ‘commitment.’ ‘Sometimes professional help may be needed, but otherwise parents can trust their own resources,’ she concludes.

Nurses’ avoidance of taking a strong position on the specificities of motherhood or parenthood in general but to have them “trust to their own resources” (mostly) and to perform parenthood in their own way can be interpreted as supporting women to become self-reliant in family life. This kind of subtle guidance may (also) be seen as empowering and enabling motherhood. However, in effect, as a support and care approach, it configures mothers as rational, self-sufficient neoliberal individuals responsible for their own (good) motherhood.

This is in line with writings on Nordic welfare state services (O’Connor et al.; Julkunen). Prior literature claims that during the last three to four decades the welfare state has had to answer growing demands for risks to be managed without determining how to be a “good citizen” for citizens. In fact, these relatively new approaches to care—subtle persuasion, abstract guidance, seemingly neutral argumentation, and growing insistence on individual choice and autonomy—can be associated with the welfare services’ responses to the demands of capitalism (Sulkunen). Above all, they can be seen as services response to the demand for increasing autonomy and choice. Regulating choices regarding lifestyle would interfere with neo-liberal individualist (consumer) freedom, agency, and responsibility and with the attempt to decentralize and privatize responsibility. Therefore, the response has been an “ethics of not taking a stand” that differs from the power techniques of the “nanny” (welfare) state, which has been

characterized as infantilizing citizens in the name of progress, universal individualism, and knowing the good life (Sulkunen 27-32; Homanen, “Controlling and Enabling Parenthood”).

The faith in individual empowerment and voluntary partnership(s) demonstrated here is further accompanied by a romantic nostalgia of community-like care in parenting decisions. The problem with practices built on the operating principles of individualism, voluntariness, and empowerment is that they may also allow control to be exercised over pregnant women. If maternity healthcare actors are not willing (anymore) to give specific content to advise on family values and wellbeing, at least officially, other partners—such as different communities and families seeking to support transition to parenthood—may step in instead (Sulkunen 152; Benhabib).

Conclusions

My study shows that in maternity healthcare today, there are two interrelated logics of providing choice and autonomy for pregnant women that both potentially enable and control motherhood. The logics stem from both medical ethical concepts and new institutional market demands, and from the long tradition in nursing of relying on experience-based knowledge gained through working with pregnant women over a long period of time. Giving pregnant women time (when it is possible) seems to be central in maternity nursing work in that it is attuned to women’s agency. Supporting choice as a process of coming to knowing one’s choices allows women the time and space to creatively build identity and family life, and then make choices accordingly realized in the support of processes of self-reliance.

However, although the method of care—guiding from a distance by not taking a stand—may prove beneficial for some women, it may also allow power to be exercised over some women: those who live in controlling communities or families. Communities may have far stronger constraints on individual choices and freedoms than the welfare state ever had (Sulkunen 152). The method of persuasion by inviting women to freely choose and be self-reliant may also be far more effective in creating constraints on women's choices than more (historical) disciplinary techniques, which also still exist. The emphasis on self-reliance and empowerment in this model of individualism in public services can be interpreted as a state response to the market demand to provide more choice and autonomy for its citizens (Sulkunen; Benhabib; Foucault, *The Birth of Biopolitics*).

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